Exhibit A

BRANCH/AGENCY 95L 818
INTERNTAL FI GP CA

MetLife
Metropolitan Life
Insurance Company

Term Life Insurance Policy

Insured BANG LIN

Policy Number 204 126 416 ET

Plan of Insurance Yearly Renewable Term with Guaranteed Premiums

Face Amount $1,000,000

Metropolitan Life Insurance Company will pay **the Face Amount of this Policy and** provide **the other rights and benefits of the Policy according to its provisions.**

Signed on the Date of Issue
for the Company at its Home Office
200 Park Avenue
New York, New York 10166

Robert H. Benmosche
Chairman of the Board,
President and Chief Executive Officer

Gwenn L. Carr
Vice-President and Secretary

Term Life Insurance Policy

- The policy proceeds are payable if the Insured dies while the insurance is in force.
- Premiums are payable to the Company for a specified period. (See the Schedule of Renewal Premiums.)
- Premiums for the first year are shown in the Policy Schedule and for later years are shown in the Schedule of Renewal Premiums.
- The Policy is not participating and does not share in dividends.
- The Policy is automatically renewable until the Final Expiry Date shown in the Policy Schedule.
- The Policy can be converted to permanent insurance within the Conversion Period shown in the Policy Schedule.

Please Read Your Policy Carefully
This policy is a legal contract between you and the Company.

Ten Day Right to Return the Policy
You have 10 days after you receive this Policy from the Company to review it. Within those 10 days, you can return the Policy to the Company or its sales representative for any reason. If you return the Policy: any premiums paid will then be refunded; and the Policy will be cancelled from the start.

Table of Contents

Pages 4, 6, 16 and 17 were intentionally left blank.

Policy Schedule

Owner and Beneficiary
As named in the Application or as later changed. See the Owner and Beneficiary Section of the Policy.

Insured	Policy Number	Age	Sex
BANG LIN	204 126 416 ET	35	MALE

Policy Date	Date of Issue	Policy Class
09/06/2004	08/31/2004	SELECT PREFERRED NONSMOKER

Expiry Date	Final Expiry Date
09/06/2005	POLICY ANNIVERSARY ON WHICH INSURED IS AGE 95

Conversion Period
UP TO THE POLICY ANNIVERSARY ON WHICH INSURED IS AGE 50

Schedule of Benefits

	Face Amount
Yearly Renewable Term with Guaranteed Premiums	$1,000,000
Waiver of Premiums - Disability of Insured (Wvr)	--

Schedule of Annual Premiums

	First Year
Current	$440.00
Wvr	$100.00
Total Premium Current	$540.00

Thereafter See the Schedule of Renewal Premiums Beginning on Page 5

Total Current Premium On	Annual	Monthly**
Policy Date	$540.00*	$48.60*

* A $ 90.00 annual Policy Fee is reflected in these amounts.
** Automatically deducted from checking account.

SEX-DISTINCT BASIS

Schedule of Renewal Premiums

Policy Number
204126416ET

Annual Renewable Premiums

Policy Year	Total Premium*	Term*	Disability Waiver
2 thru 15	$540.00	$440.00	$100.00
16	$13770.00	$8490.00	$5280.00
17	$15070.00	$9290.00	$5780.00
18	$16560.00	$10230.00	$6330.00
19	$18250.00	$11280.00	$6970.00
20	$20190.00	$12500.00	$7690.00
21	$22320.00	$13850.00	$8470.00
22	$24720.00	$15370.00	$9350.00
23	$27250.00	$16980.00	$10270.00
24	$30040.00	$18740.00	$11300.00
25	$33190.00	$20740.00	$12450.00
26	$36710.00	$22970.00	$13740.00
27	$40630.00	$25460.00	$15170.00
28	$45140.00	$28310.00	$16830.00
29	$50270.00	$31570.00	$18700.00
30	$56080.00	$35280.00	$20800.00
31	$39390.00	$39390.00	-
32	$43850.00	$43850.00	-
33	$48700.00	$48700.00	-
34	$53960.00	$53960.00	-
35	$59710.00	$59710.00	-
36	$66230.00	$66230.00	-
37	$73650.00	$73650.00	-
38	$82230.00	$82230.00	-
39	$92600.00	$92600.00	-
40	$103810.00	$103810.00	-
41	$115920.00	$115920.00	-
42	$128900.00	$128900.00	-
43	$142650.00	$142650.00	-
44	$157030.00	$157030.00	-
45	$171530.00	$171530.00	-
46	$187430.00	$187430.00	-
47	$205130.00	$205130.00	-
48	$225130.00	$225130.00	-
49	$247670.00	$247670.00	-
50	$272310.00	$272310.00	-

*A $90.00 annual Policy Fee is included in these amounts.

Schedule of Renewal Premiums

Policy Number
204126416ET

Annual Renewable Premiums

Policy Year	Total Premium*	Term*	Disability Waiver
51	$298490.00	$298490.00	-
52	$325690.00	$325690.00	-
53	$353670.00	$353670.00	-
54	$381870.00	$381870.00	-
55	$410670.00	$410670.00	-
56	$440470.00	$440470.00	-
57	$471770.00	$471770.00	-
58	$505590.00	$505590.00	-
59	$543350.00	$543350.00	-
60	$591390.00	$591390.00	-

*A $90.00 annual Policy Fee is included in these amounts.

Payment When Insured Dies

Policy Proceeds

If the Insured dies while this policy is in force, an amount of money, called the policy proceeds, will be payable to the beneficiary. The policy proceeds are the total of:

* The Face Amount shown in the Policy Schedule;

PLUS

* Any part of a premium paid for coverage beyond the date of death;

PLUS

* Any amount of insurance on the Insured's life which may be provided by a rider on this Policy;

MINUS

* Any premium due to the date of death.

We will pay the policy proceeds to the beneficiary after the receipt of proof of death and a proper written claim. (See Payment provision in Payment of Benefits section.)

Contract

The Contract

This Policy is a legal contract between the Owner of the Policy (called "you") and Metropolitan Life Insurance Company (called "the Company"). The Policy, which includes the attached Applications, any attached endorsements and all riders listed in the Policy Schedule, is the entire contract between you and the Company. No change in or waiver of the provisions of the Policy is valid unless the change or waiver is signed by the President or the Secretary of the Company.

Payments Under the Contract

All contract amounts are in U.S. currency. Payments by the Company under the contract will be made at the Home Office or at any other office designated by the Company. The obligations of the Company are subject to all payments made and actions taken by the Company under the Policy before we record proof of the Insured's death at our Home Office or at any office designated by the Company.

Forms

If you want to change a beneficiary, change an address, convert this policy or request any other action by us, you should do so on the forms prepared for each purpose. You can get these forms from your sales representative or from our Home Office or from any other office designated by the Company.

Dates

Policy years, months and anniversaries are all measured from the Policy Date. The contestable and suicide periods start on the Date of Issue. The Policy Date and the Date of Issue are both shown in the Policy Schedule.

Not Contestable After Two Years

Insurance is issued by the Company in reliance on the statements made in the Application for the insurance. Those statements are representations; they are not warranties. No statement can be used to contest or rescind insurance or to defend against a claim unless contained in the Application for the insurance. The insurance issued under this Policy will not be contestable after it has been in force during the life of the Insured for two years from the Date of Issue, except for nonpayment of premiums.

Suicide Within Two Years

If the Insured dies by suicide, while sane or insane, within two years from the Date of Issue, the policy proceeds will be limited to the amount of the premiums paid, or the reserve if greater and required by state law.

Age of Insured

The age of the Insured on the Policy Date and on policy anniversaries means the age at the nearest birthday of the Insured.

If the age or the sex of the Insured has not been correctly stated in the Application, the benefits will be the amounts which the premiums paid would have purchased for the correct age and sex.

Unisex Basis	If the Policy Schedule indicates this Policy is on a Unisex Basis, each Policy or rider provision that contains any differences based on sex is modified to provide for males and females the same: * Rates; * Benefits; and * Values.
Claims of Creditors	The Policy and payments under it will be exempt from the claims of creditors to the extent allowed by law.
Refund of Unearned Premiums	If you ask to discontinue this Policy, we will refund the part of the premium paid for coverage beyond the policy month in which you make your request.

Premiums

Payment

Premiums are payments to the Company for the Policy. Payments can be made at the Home Office or at any other office designated by the Company. All payments are to be made in U.S. currency. A receipt for payment signed by the Secretary of the Company will be given on request. The Policy will not be in force until the first full premium is paid.

Amount and Frequency

Annual premiums for the Policy and for any riders are shown in the Policy Schedule and in the Schedule of Renewal Premiums. Payment can be at any other premium mode available by the Company. Payment is due in advance on the first day of each payment period, starting on the Policy Date. No premium will be due or payable for any period after the death of the Insured.

Grace Period

There is a grace period of 31 days in which to pay each premium after the first, without interest, after its due date. The insurance will be in force during the grace period.

Renewal

The Policy will be renewed automatically for successive periods of one year from the Expiry Date to a new Expiry Date one year later by payment of the renewal premium. It cannot be renewed beyond the Final Expiry Date shown in the Policy Schedule.

Reinstatement

If the Policy lapses because a premium is unpaid at the end of its grace period the Policy and riders can be reinstated, if the Insured is living.

We will reinstate your Policy if you:

* Apply for reinstatement within 3 years of the due date of the premium in default; and
* Provide evidence of insurability satisfactory to the Company; and
* Pay, while the Insured is living, each unpaid premium, plus interest at the rate of 6% per year compounded yearly.

Any rider which provides life or disability insurance on a person other than the Insured can be reinstated only as stated in the rider.

Conversion Option

Conversion Option

During the Conversion Period shown in the Policy Schedule you can convert this Policy, while it is in force with all premiums paid, to a new policy on another plan of insurance. The new policy will be issued:

* By the Company or by an affiliate designated by the Company;
* Without proof that the Insured is insurable;
* On any plan of permanent insurance, with a level face amount, available on the Policy Date of the new policy;
* With the same Insured and Face Amount as this Policy;
* With the same underwriting class as this Policy, or the class we determine is closest to it if the class of this Policy is not offered on the new policy;
* Subject to any assignments of this Policy and any limitations on this Policy stated in riders,
* With a Policy Date as of the date of conversion; and
* At the insurance age of the Insured on the Policy Date of the new policy.

The conversion is subject to payment of the first premium for the new policy, less any conversion credit.

Riders can be attached to the new policy only with the consent of the Company.

Owner and Beneficiary

Owner

The Owner of the Policy is named in the Application (see copy attached); but the Owner can be changed. The new Owner will succeed to all of the rights of the Owner, including the right to make a further change of Owner. At the death of the Owner, his or her estate will be the Owner, unless a successor Owner has been named. In this Policy "you" means the Owner, whether the Owner is a person, a partnership, a corporation, a fiduciary or any other legal entity. The rights of the Owner will end at the death of the Insured.

Beneficiary

The Beneficiary is the person or persons to whom the policy proceeds are payable when the Insured dies. The Beneficiary is named in the Application (see copy attached); but the Beneficiary can be changed before the death of the Insured. You may name a Contingent Beneficiary who would become the Beneficiary if the Beneficiary dies before the Insured dies. The Beneficiary has no rights in the Policy until the death of the Insured. A person must survive the Insured to qualify as Beneficiary. If none survives, the proceeds will be paid to the Owner. The Beneficiary can also be a corporation, a partnership, a fiduciary or any other legal entity.

Change of Owner or Beneficiary

A change of Owner or Beneficiary must be in written form satisfactory to the Company, and must be dated and signed by the Owner who is making the change. The change will be subject to all payments made and actions taken by the Company under the Policy before the signed change form is recorded at our Home Office or other office designated by the Company.

Assignments

An absolute assignment of the Policy by the Owner is a change of Owner and Beneficiary to the assignee. A collateral assignment of the Policy by the Owner is not a change of Owner or Beneficiary; but their rights will be subject to the terms of the assignment. Assignments will be subject to all payments made and actions taken by the Company before a signed copy of the assignment form is recorded at our Home Office or at any other office designated by the Company. The Company will not be responsible for determining whether or not an assignment is valid.

Designation of Owner and Beneficiary

A numbered sequence can be used to name successive Owners or Beneficiaries. Co-Beneficiaries will receive equal shares unless otherwise stated.

At the time for payment of benefits the Company can rely on an affidavit of any Owner or other responsible person to determine family relations or members of a class.

Payment of Benefits

Payment

Unless otherwise requested, we may pay the policy proceeds when the insured dies, to the Payee in one sum or by placing the amount in an account that earns interest. The Payee will have immediate access to all or any part of the account. The Company will pay interest on the proceeds from the date they become payable to the date of payment as stated above at the rate of interest that will be set each year by the Company and that will not be less than that required by law or 3% per year, if greater.

On request, all or part of the proceeds payable in one sum at the death of the Insured can be applied to any Payment Option at the choice of the Payee. Further, with the consent of the Company, any Payee who is entitled to receive proceeds in one sum when a Payment Option ends, or at the death of a prior Payee, or when the proceeds are withdrawn, can choose to apply the proceeds to a Payment Option.

Choice of Payment Options; Option Date

The choice of a Payment Option and the naming of the Payee must be in written form satisfactory to the Company. You can make or change or revoke the choice before the death of the Insured. The Option Date is the effective date of the Payment Option, as chosen.

When a Payment Option starts, we will issue a contract which will describe the terms of the Option. We may require that you send us this Policy

Payee

A Payee is a person, a corporation, a partnership, a fiduciary or any other legal entity entitled to receive payment in one sum or under a Payment Option.

If the Payee is not a natural person, the choice of a Payment Option will be subject to our approval. A collateral assignment will modify a prior choice of a Payment Option. The amount due the assignee will be payable in one sum and the balance will be applied under the Payment Option.

Life Income Options

Guaranteed Life Income Options are based on the age of the Payee on the Option Date. The Company will require proof of age. The Life Income payments will be based on the rates shown in the Life Income Tables; or, if they are greater; the Payment Option rates of the Company on the Option Date. If the rates at a given age are the same for different periods certain, the longest period certain will be deemed to have been chosen.

Death of Payee

Amounts to be paid after the death of a Payee under a Payment Option will be paid as due to the successor Payee. If there is no successor Payee, amounts will be paid in one sum to the estate of the last Payee to die. If a Payee under a Life Income Option dies within 30 days after the Option Date, the amount applied to the Option, less any payments made, will be paid in one sum, unless a Payment Option is chosen.

Limitations

If instalments under an Option would be less than $50, proceeds can be applied to a Payment Option only with the consent of the Company.

Payment Options

Interest Income

The proceeds applied to this Option will earn interest. Interest on the proceeds:

* Will be paid monthly; or
* Will be added to the principal amount each year and will earn interest.

Withdrawals of at least $500 each may be made at any time by written request.

Instalment Income for a Stated Period

Monthly instalment payments will be made so that the proceeds applied, with interest, will be paid over the period chosen (from 1 to 30 years). Any interest paid above 3% (See Payment Option Rates below) by the Company for any year will be added to the monthly payments for that year.

Instalment Income of a Stated Amount

Monthly instalment payments of a chosen amount will be made until the entire proceeds applied, with interest, is paid.

Single Life Income – Guaranteed Payment Period

Monthly payments will be made during the lifetime of the Payee with a chosen guaranteed payment period of 10, 15 or 20 years.

Single Life Income – Guaranteed Return

Monthly payments will be made during the lifetime of the Payee. If the payee dies before the total amount applied under this plan has been paid, the remainder will be paid in one sum.

Joint and Survivor Life Income

Monthly payments will be made:

* While either of two Payees is living, but for at least 10 years, called "Joint and Survivor Life Income, 10 Years Certain"; or
* While two Payees are living, and after the death of one Payee, two-thirds of the monthly amount while the other Payee is living, called "Joint and 2/3 to Survivor Life Income".

Other Frequencies and Options

Other Payment Options and payment frequencies may be arranged with us.

Payment Option Rates

Amounts applied under the interest income and instalment payment plans will earn interest at a rate we set from time to time; but the rate will not be less than 3% per year.

Life Income Tables

Minimum Payments under Payment Options

Monthly payments for each $1,000 applied will not be less than the amounts shown in the following Tables. On request, we will provide additional information about amounts of minimum payments.

The rates shown below are based on an interest rate of 3% per year and based on the 1983 IAM Mortality Table with projection to 1992 using projection Scale G.

Instalment Income for a Stated Period

Years Chosen	Monthly Payment	Years Chosen	Monthly Payment	Years Chosen	Monthly Payment
1	$84.47	11	$8.86	21	$5.32
2	42.86	12	8.24	22	5.15
3	28.99	13	7.71	23	4.99
4	22.06	14	7.26	24	4.84
5	17.91	15	6.87	25	4.71
6	15.14	16	6.53	26	4.59
7	13.16	17	6.23	27	4.47
8	11.68	18	5.96	28	4.37
9	10.53	19	5.73	29	4.27
10	9.61	20	5.51	30	4.18

Single Life Income

Payee's Age	Guaranteed Payment Period			Guaranteed Return
	10 Years	15 Years	20 Years	
50	$3.48	$3.47	$3.45	$3.41
55	3.72	3.70	3.66	3.61
60	4.02	3.98	3.92	3.86
65	4.40	4.33	4.21	4.17
70	4.90	4.76	4.54	4.57
75	5.55	5.25	4.87	5.06
80	6.34	5.77	5.13	5.69
85 and over	7.25	6.21	5.28	6.49

Joint and Survivor Life Income

Age of Both Payees	Joint and Survivor, 10 Years Certain	Joint and 2/3 to Survivor
55	$3.36	$3.48
60	3.58	3.73
65	3.87	4.05
70	4.25	4.48
75	4.76	5.07

Rider: Waiver of Premium Due to Disability of Insured

The Company will waive premiums for the Policy and all Riders on receipt of proof that total disability of the Insured: begins while this Rider is in force, and continues for at least six months. Any premiums due before the Company approves a claim for waiver of premium should be paid as due; however, the Company will refund to the Owner any premium paid but later waived. This agreement is subject to the following provisions

Disability Starting Before Age 60

If total disability starts prior to the policy anniversary on which the Insured is age 60, any premium becoming due will be waived while the Insured remains totally disabled. If this total disability continues uninterrupted until the policy anniversary on which the Insured is age 65, such disability will be deemed to continue thereafter and any further premiums will be waived as they fall due. Premiums will not be waived for any period more than one year before written notice and proof of claim is received at: our Home Office; or at any other office designated by the Company.

Disability Starting Between Ages 60 and 65

If total disability starts on or after the policy anniversary on which the Insured is age 60, but before the policy anniversary on which the Insured is age 65, premiums becoming due will be waived while the insured remains totally disabled. These premiums will be waived until the later of: (a) the policy anniversary on which the Insured is age 65; and (b) the third policy anniversary after disability starts. Any premiums becoming due thereafter must be paid as provided in the Policy. Premiums will not be waived for any period more than one year before written notice and proof of claim is received at: our Home Office; or at any other office designated by the Company.

Definitions

"Total disability" means disability of the Insured which:

* Results from bodily injury or disease; and
* Continuously prevents the Insured from working for pay or profit.

During the first 36 months of disability, "working" means engaging in the regular occupation, business or profession of the Insured; and thereafter means engaging in any occupation, business or profession for which the Insured is or becomes reasonably qualified by education, training or experience.

"Working for pay or profit" includes attending school or college as a full-time student, if that was the Insured's main occupation when the disability began.

The Insured will be deemed to be prevented from working, even while working for pay or profit, if the Insured has a total and continuing loss of:

* Sight or hearing or speech; or
* Use of both hands; or
* Use of both feet; or
* Use of one hand and one foot.

Rider: Waiver of Premium Due to Disability of Insured (Continued)

Exclusions

No premiums will be waived under this Rider for disability resulting from:

* An act or incident of war, declared or undeclared; nor
* Any bodily injury which occurred or disease which first manifested itself before the Date of Issue of this Rider if total disability begins within two years after the Date of Issue of the Rider; nor
* Intentionally self-inflicted injury or disease.

Notice and Proof of Disability

No premium will be waived unless proof of disability is received by the Company:

* During the life of the Insured; and
* During continuance of the disability.

If it is not reasonably possible to provide proof within the time required, the waiver benefits will not be reduced, provided proof is received, except in the absence of legal capacity, not more than one year late.

Proof of continuance of disability may be required by the Company at reasonable intervals; but after two years of continuous total disability, proof will not be required more often than once a year. We may require medical examination of the Insured by physicians we name, at our expense.

Premiums For This Rider

Premiums for this Rider are due with the premiums for the Policy. The first year and renewal premiums for this Rider are shown respectively on page 3 and page 5 of the Policy. No premium will be due or payable for the Rider for any period after the death of the Insured or the termination of the Rider.

Date of Issue

The Date of Issue of this Rider is the same as the Date of Issue of the Policy unless a different Date of Issue is shown for the Rider in the Policy Schedule.

Not Contestable After Two Years

The Company will not contest or rescind this Rider after it has been in force during the life of the Insured, and without the occurrence of total disability of the Insured, for two years from the Date of Issue of the Rider.

Contract

A copy of the application for this Rider is attached to and made a part of the Policy. This Rider is made a part of the Policy to which it is attached if the Rider is listed in the Policy Schedule.

Rider: Waiver of Premium Due to Disability of Insured (Continued)

Termination

This Rider will end upon the earliest of: (a) failure to pay any premium for the Policy or for the Rider by the end of the premium grace period; (b) the policy anniversary on which the Insured is age 65; (c) termination of the Policy; and (d) the Company's recording of a written request signed by the Owner to end the Rider.

Termination of this Rider on the policy anniversary on which the Insured is age 65 will have no effect on your claim if the Insured is then disabled.

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166

Robert H. Benmosche
Chairman of the Board,
President and Chief Executive Officer

Gwenn L. Carr
Vice-President and Secretary

PART II: Paramedical/Medical Exam

Case/Policy No.: 20412647 86

- [X] Metropolitan Life Insurance Company
- [ ] MetLife Investors Insurance Company of California
- [ ] New England Life Insurance Company
- [ ] Texas Life Insurance Company
- [ ] Metropolitan Tower Life Insurance Company
- [ ] Metropolitan Insurance and Annuity Company
- [ ] MetLife Investors USA Insurance Company
- [ ] General American Life Insurance Company

The Company indicated above is referred to as "the Company".
For Texas Life: If medical examination *is not* required, questions are to be completed by Agent.

The spaces below are for answers of person to be examined only. Nothing but the answers of such person should be recorded.

1. Name of Proposed Insured: (Last, First, Middle) LIN. BANG C — Date of Birth: (Mo./Day/Year) 08-06-1969

2. Tobacco Use – Indicate date last smoked/used:

Cigarette	Smokeless Tobacco	Cigar/Pipe	Patch/Gum
__/__/__ [X] Never	__/__/__ [X] Never	__/__/__ [X] Never	__/__/__ [X] Never

Amount/Frequency: — Tobacco Never Used: [X] Yes [ ] No

3. Who is the doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health? If "None", check [ ].

Name, full address, and phone number: DR. JAMES HUANG (714) 990-0378
340 WEST Central AVE #119. BREA, CA 92821

When was this doctor last consulted? 08/2004 — Why? Skin itching

What treatment was given or medication prescribed? If "None", check [X]

Reasons, findings, earlier consultations past 5 years? — WNL

4. a) Height 5 ft. 8 in. b) Weight 170 lbs. c) Change in weight in past 12 months (give reason) Pounds lost 0 Pounds gained 0 Reason

6.

Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:		Details: List question number. Give: details; dates; duration; diagnosis; treatment; and doctors' names and addresses.
a) High blood pressure; chest pain, heart attack; or any other disease or disorder of the heart or circulatory system?	[ ] Yes [X] No	
b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	[ ] Yes [X] No	
c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Lou Gehrig's disease (ALS); memory loss; Parkinson's disease; progressive neurological disorder; headaches; dizziness; or any other disease or disorder of the brain or nervous system?	[ ] Yes [X] No	
d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of: the liver, gallbladder; stomach; or intestines?	[ ] Yes [X] No	
e) Any disease or disorder of: the kidney; bladder; prostate; reproductive organs; or breasts; sexually transmitted disease; sugar; albumin; blood or pus in the urine?	[ ] Yes [X] No	
f) Diabetes; thyroid disorder; or any other endocrine disorder?	[ ] Yes [X] No	
g) Arthritis; gout; or disorder of the muscles, bones, or joints?	[ ] Yes [X] No	
h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin?	[ ] Yes [X] No	

Details (Continued):

	i) Anemia; leukemia; or any other disorder of the blood or lymph glands?	☐ Yes ☒ No	
	j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐ Yes ☒ No	
	k) Any disease or disorder of the eyes, ears, nose, or throat?	☐ Yes ☒ No	
6.	Are you now, or within the last six months, under observation or taking medication or treatment? (including over the counter medications, vitamins, herbal supplements, etc.)	☐ Yes ☒ No	
7.	Do you have any doctor's visits, medical care, or surgery scheduled?	☐ Yes ☒ No	
8.	Other than the above, during the past five years have you had any:		
	a) Checkup; electrocardiogram; chest x-ray; or medical test?	☐ Yes ☒ No	
	b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?	☐ Yes ☒ No	
9.	Have you:		
	a) ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	☐ Yes ☒ No	
	b) ever tested positive during a medical examination for life insurance for the AIDS (HIV) virus or for antibodies to the AIDS (HIV) virus?	☐ Yes ☒ No	
10.	a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐ Yes ☒ No	
	b) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐ Yes ☒ No	

11. Do you exercise? ☒ Yes ☐ No Type: SWIMMING / GOLF How often? 2 times to 3 hrs

12. Are you now pregnant? ☐ Yes ☒ No If "Yes", estimated date of delivery? _____

13. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, indicate below.) ☐ Yes ☒ No

Relationship to Proposed Insured:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

14. a) Do you currently use any mechanical equipment such as a walker, wheelchair, long leg braces or crutches? ☐ Yes ☒ No.

b) Do you need any assistance or supervision with the following activities: bathing, dressing, walking, moving in/out of a chair or bed, toileting, continence or taking medication? ☐ Yes ☒ No

I have read the answers to questions 2-14 before signing. They have been correctly written, as given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Witness to Signature	City and State	Mo./Day/Year	Signature of Proposed Insured (Parent or Guardian if under 18)
[signature]	IRVINE, CA	08/18/04	[signature]

Chou Peggy

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Part I

Company Use Only (Policy Numbers/Billing/MSA Number)

☑ Metropolitan Life Insurance Company
☐ New England Life Insurance Company ☐ General American Life Insurance Company
☐ MetLife Investors USA Insurance Company ☐ MetLife Investors Insurance Company

The Company indicated above is referred to as "the Company".

1. Proposed Insured #1: Life 1

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number
BANG LIN	M	8/6/69	TAIWAN	085-66-4606

a) Current Residence Address and Phone Number:
7 GREEN HOLLOW, IRVINE, CA 92620
(Street) (City) (State) (Zip)
(714) 734-3029 (Home Phone) (858) 756-2222 (Work Phone) Best time and place to call: afternoon ☐ a.m. ☐ p.m. ☐ Home ☑ Work

E-Mail Address:

b) Driver's License Number and State of Issue: A9644172 exp. 8/6/08

c) Employer's Name: Xin Msia

d) Occupation & Duties: President

e) Earned Annual Income: $ 150,000- Net Worth: $ 2,500,000-

f) Are you actively at work? ☑ Yes ☐ No (If No, provide details)

2. Proposed Insured #2: Life 2 or Spouse/Covered Insured/Applicant's Waiver of Premium Benefit (For multiple persons under a Covered Insured rider, complete Other Insureds Supplement for additional persons.)

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number	Relationship to Proposed Insured #1

a) Current Residence Address and Phone Number (if different than Proposed Insured #1):

(Street) (City) (State) (Zip)
( ) (Home Phone) ( ) (Work Phone) Best time and place to call: ☐ a.m. ☐ p.m. ☐ Home ☐ Work

E-Mail Address:

b) Driver's License Number and State of Issue:

c) Employer's Name:

d) Occupation & Duties:

e) Earned Annual Income: $ Net Worth: $

f) Are you actively at work? ☐ Yes ☐ No (If No, provide details)

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3. Existing or applied for insurance, including any term riders or annuities: (If additional space is needed, provide details in the Supplemental Information section. If any existing insurance, complete state replacement forms as necessary.) If no existing or applied for insurance or annuity, check here. ☐ **[Type: Life (L), Disability (D), Health (H), Annuity (A)]**

Proposed Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	1035
Insured	MetLife	L	500K	99	500,000 –	☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

4. In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? (If Yes, complete the Replacement Questionnaire and Disclosure and any applicable replacement forms.) ☐ Yes ☒ No

5. Indicate Plan and Face Amount: ☐ **list below or** ☐ **complete Product Supplement.**

a) Type of Insurance: ☒ Individual Life ☐ Survivorship/Joint Life

☐ Group Conversion (For MetLife only.) (Complete Product Supplement.) ☐ Qualified Plan (Employee Group Number _____)

b) Plan: 15 years Term c) Face Amount: $ 1,000,000 –

Complete for Universal Life/Variable Life Products. (For Variable Life, also complete Variable Life Supplement.)

d) Planned Premium (modal): Year 1: $ _____ Excess/Lump Sum: $ _____

Renewal (If applicable): $ _____ Planned Annual Unscheduled Payment (If applicable): $ _____

e) Definition of Life Insurance Test (If choice is available under policy applied for.):

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

f) Death Benefit Option/Contract Type: _____

g) Guarantee to Age: _____ or ☐ 5 Years (for MetLife Variable only.)

h) **Optional Benefits/Riders/Dividend Option:** ☐ **list below or** ☐ **complete Product Supplement.**

Disability Waiver	

i) **Special Requests/Other: list below**

$72 / month

j) Do you request an alternate/additional policy (If available)? ☐ Yes ☐ No
(If Yes, provide full details in Supplemental Information section and include signed and dated illustration for each policy requested.)

6. MODE OF PAYMENT

a) Mode of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☒ Bank Draft
☐ Special Accounts _____ ☐ Other _____

(Additional details/existing/new account numbers, etc.): _____

b) Amount collected with application $ 72 / must equal at least one monthly premium.

7. SOURCE OF PAYMENT (Check all that apply:)

☐ Earned Income ☐ Money Market Fund ☐ Certificate of Deposit
☐ Rollover/Transfer of Assets ☒ Savings ☐ Loan ☐ Other _____
☐ Mutual Fund/Brokerage Account ☐ Use of values in another Life Insurance/Annuity Contract

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8. What is the purpose of this insurance? (Check all that apply:) ☐ Income Protection ☐ Business Planning
☐ Estate Planning ☒ Mortgage Protection ☐ Retirement Supplement ☐ Education Funding
☐ Final Expenses ☐ Charitable Giving ☐ Other _____

Provide the following information for all Primary/Contingent Owners and Beneficiaries:
name; relationship to Proposed Insured(s); date of birth; social security/tax ID number; and address. Include E-Mail address. If Trust, provide Trustee Name and Date of Trust. Indicate additional: Owners; Contingent Owners; Primary Beneficiaries; and Contingent Beneficiaries in Supplemental Information section.

9. **Owner/Contingent Owner Information**

a) Identity of Owner: Proposed Insured #1 ☒ #2 ☐

Jean Lin
5/19/71
Spouse
128-64-5329

b) Identity of Contingent Owner (if applicable):

10. **Beneficiary Information**

Note: Multiple beneficiaries will receive equal proceeds unless otherwise requested by Owner.

a) Identity of Primary Beneficiary: ☐ Owner

Jean Lin
5/19/71 Spouse
128-64-5329

b) Identity of Contingent Beneficiary:

Chelsey Lin 50%
11/3/96
daughter
S.S.#: 626-92-1165

Angus Lin 50%
11/9/95
S.S.#: 604-86-5448
Son

☐ Check here if all present and future natural or adopted children of Proposed Insured #1 are to be included as Contingent Beneficiaries.

11. Billing/Mailing Address:*

☒ Proposed Insured #1 Residence Address:*
☐ Proposed Insured #2 Residence Address
☐ Owner's Address (If not Owner listed in question 9a, indicate name and address below.)
☐ Primary Beneficiary's Address (If not Beneficiary listed in question 10a, indicate name and address below.)
☐ Other Premium Payer (Indicate name and address below.)
(If Other, indicate relationship to Proposed Insured(s).) _____ Relationship

_____
(Name: Address: Street City/ State/ Zip)

*If any other special mailing arrangements are needed, indicate in Supplemental Information section.

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12. Is any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) ☐ Yes ☒ No

a) Amount of insurance on spouse: Existing: $ _____ Applied For: $ _____

b) If dependent minor, are there any other siblings insured for less than this child? (If Yes, provide details in Supplemental Information section.) ☐ Yes ☒ No

c) Amount of existing and applied for insurance on parents of dependent minor:

Father's Name	Amount Existing	Amount Applied For	Mother's Name	Amount Existing	Amount Applied For

Part II

13. Within the past three years has any person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? (If Yes, complete Aviation Supplement.) ☐ Yes ☒ No

14. Within the past three years has any person to be insured participated in or intend to participate in any: underwater sports (SCUBA diving, hardhat, skin diving, snorkeling); sky sports (skydiving, hang gliding, parachuting, ballooning); racing sports (motorcycle, auto, motor boat); rock or mountain climbing; bungee jumping or other similar activities? (If Yes, complete Avocation Supplement.) ☐ Yes ☐ No

15. Are all persons to be insured U.S. citizens? (If No, provide details below including: country of citizenship; Visa/ID Card type; number; and expiration date.) ☒ Yes ☐ No

16. Has any person to be insured traveled or resided outside the U.S. or Canada in the past two years OR does any person to be insured intend to travel or reside outside the U.S. or Canada in the next 12 months? (If Yes, provide details below including: country; city; duration; and purpose.) ☐ Yes ☐ No

17. Has any person to be insured ever used tobacco products: (e.g. cigarettes; cigars; pipes; smokeless tobacco; chew) or nicotine substitutes: (e.g. patch or gum)? (If Yes, provide type, amount, date last used, and frequency below.) ☐ Yes ☒ No

18. Has any person to be insured: ever had a driver's license suspended or revoked; ever been convicted of DUI or DWI; or had any moving violations in the last five years? (If Yes, provide details below.) ☐ Yes ☒ No

Give details for question 15 through 18. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number(s)	Date	Details

19. Attending Physician(s) of the Proposed Insured(s): (Provide: name; address; phone number; date; and reason for last consultation. Attach additional sheet(s), if necessary.)

Proposed Insured #1

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment
Dr. S James Hwang 340 W. Central Ave. #119 Brea, CA 92821 714-990-0325	8/04 Regular check up Normal

Proposed Insured #2

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment

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20. Proposed Insured #1 Height: 5'6" Weight: 165	Proposed Insured #2 Height: _____ Weight: _____

21. Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:
(Provide details for each Yes answer below.)

a) High blood pressure; chest pain; heart attack; or any other disease or disorder of the heart or circulatory system? ☐ Yes ☑ No
b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the respiratory system? ☐ Yes ☐ No
c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Parkinson's; or any other disease or disorder of the brain or nervous system? ☐ Yes ☑ No
d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines? ☐ Yes ☑ No
e) Any disease or disorder of: the kidney; bladder; or prostate; or protein or blood in the urine? ☐ Yes ☑ No
f) Diabetes; thyroid disorder; or any other endocrine disorders? ☐ Yes ☑ No
g) Arthritis; gout; or disorder of the muscles, bones, or joints? ☐ Yes ☐ No
h) Cancer; tumor; polyp; cyst; anemia; leukemia; or any other disorder of the blood or lymph glands? ☐ Yes ☐ No
i) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? ☐ Yes ☐ No

22. Has any person proposed for insurance: (Provide details for each Yes answer below.)

a) In the past six months, taken any medication or been under observation or treatment? ☐ Yes ☑ No
b) Scheduled any: doctor's visits; medical care; or surgery for the next six months? ☐ Yes ☐ No
c) During the past five years had any: checkup; health condition; or hospitalization not revealed above? ☐ Yes ☐ No
d) Ever been diagnosed with, treated by a medical professional for, or tested positive during a medical examination for life insurance for; any of the following: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); AIDS (Human Immunodeficiency Virus (HIV)) virus; or antibodies to the AIDS (HIV) virus? ☐ Yes ☐ No
e) Ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? ☐ Yes ☑ No
f) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? ☐ Yes ☐ No

23. Answer Question 23 only when requesting the Long-Term Care Guaranteed Purchase Option.
(Provide details for each Yes answer below.)

a) Do you currently use any mechanical equipment i.e.: a walker; wheelchair; leg braces; or crutches? ☐ Yes ☐ No
b) Do you need any assistance; or supervision with the following activities bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication? ☐ Yes ☐ No

Give details of each Yes answer from Questions 21, 22, and 23. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number	Name/Address of Physician	Date/Duration Illness	Diagnosis/Severity/Treatment

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24. Has a parent or sibling of any person to be insured ever had heart disease, coronary artery disease, high blood pressure, cancer, diabetes or mental illness? (If Yes, complete rest of question 24.) ☐ Yes ☒ No

Relationship to Proposed Insured #1:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Relationship to Proposed Insured #2:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Supplemental Information Section or Special Requests from Agent/Producer. Attach additional sheet(s) if necessary.

Home Office Endorsements: (Not applicable to: FL, KY, MD, MA, MN, MO, OR, PA, PR, WV, WI.)

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AGREEMENT/DISCLOSURE

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- My acceptance of any insurance policy means I agree to any changes shown in the Home Office Endorsements section, where state law permits Home Office endorsements.
- This application and any: amendment(s); paramedical/medical exam; and supplement(s) that become part of the application, will be attached to and become part of the new policy.
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and its supplement(s), paramedical/medical exam, and amendment(s).
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 4 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.
- If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.

Substitute Form W-9 – Request for Taxpayer Identification Number

Under penalties of perjury, I, Jean Lin (Owner's Name) (128-64-5329 (Owner's Taxpayer ID #)) **certify:**

1) **That the number shown above is my correct taxpayer identification number; and**
2) **That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and**
3) **I am a U.S. citizen or a U.S. resident for tax purposes.***

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form **W-8BEN.**

Signatures:

	Signed at City, State	Mo./Day/Yr.	Signature
Owner* (age 15 or over) (If other than a Proposed Insured)	Irvine, CA	8/5/04	X
Proposed Insured #1 (age 15 or over)	Irvine, CA	8/5/04	X
Proposed Insured #2 (age 15 or over)			X
Parent or Guardian or person liable for child's support			X

(Signature required if Owner or Proposed Insured(s) is/are under the age of 18 and the Parent, Guardian or person liable for the child's support has not signed above.)

Witness to Signatures (Licensed Agent/Producer)	Irvine, CA	8/5/04	X

***If the Owner is a Firm or Corporation, include Officer's Title with signature. (Officer signing must be other than a Proposed Insured.)**

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TRUE COPY
6-27-07

Please notify the Company of any change in your name or address. The Company will write to you at your address on record with the Company.

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166

1-800 -MET-5000

Term Life Insurance Policy

- The policy proceeds are payable if the Insured dies while the insurance is in force.
- Premiums are payable to the Company for a specified period. (See the Schedule of Renewal Premiums.)
- Premiums for the first year are shown in the Policy Schedule and for later years are shown in the Schedule of Renewal Premiums.
- The Policy is not participating and does not share in dividends.
- The Policy is automatically renewable until the Final Expiry Date shown in the Policy Schedule.
- The Policy can be converted to permanent insurance within the Conversion Period shown in the Policy Schedule.